RAPID ASSESSMENT
OF SEXUAL AND
REPRODUCTIVE HEALTH
AND HIV LINKAGES
This summary highlights the experiences, results and actions from the implementation of the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages in Morocco. The tool – developed by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives in 2009 – supports national assessments of the bi-directional linkages between sexual and reproductive health (SRH) and HIV at the policy, systems and services levels. Each country that has rolled out the tool has gathered and generated information that will help to determine priorities and shape national plans and frameworks for scaling up and intensifying linkages. Country experiences and best practices will also inform regional and global agendas.

**RECOMMENDATIONS**

What recommendations did the assessment produce?

- The report of the assessment outlines a strategy for integration, with five main points:
  1. Developing a coordinated global response on SRH and HIV.
  2. Improving the quality of care.
  4. Better access to services.
  5. Strengthening prevention and testing for HIV.

- Gender, human rights, stigma and discrimination will be addressed in a cross-cutting manner. Key activities include:
  - Defining and implementing a reproductive health (RH) and HIV policy and action plan, specifying priority areas based on the Cairo Declaration and establishing a focal point for planning, management and monitoring.
  - Improving access to integrated RH and HIV services for all target populations.
  - Improving the population’s level of knowledge on RH and HIV.
  - Improving the capacity of service providers to provide integrated RH and HIV services.
  - Establishing an integrated monitoring system.
  - Conducting studies on integration and impact, using comparative analysis.
  - Strengthening institutional partnerships between the Ministry of Health (MOH) and key partners.

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1. This summary is based upon: Evaluation Rapide de la Situation pour l’Intégration de la Prévention du VIH/ SIDA dans la Santé Sexuelle et Reproductive, Ministère de la Santé, Morocco, and UNFPA, February 2009.
1. Who managed and coordinated the assessment?
- The assessment took place during October 2008 to January 2009.
- Decisions were made by the MoH. Planning and budget management were carried out by the MoH and UNFPA Morocco.

2. Who was in the team that implemented the assessment?
- The assessment involved: Government (MoH central level, four regional health divisions and the Ministry of National Education); civil society (Association de Lutte contre le Sida – ALS, Association Marocaine de Planification Familiale – AMPF, IPPF Morocco, Organisation Panafrique de Lutte contre le Sida – OPALS; Association du Jour, representing people living with HIV [PLHIV]; and international agencies – Global Fund to Fight AIDS, Tuberculosis and Malaria – GFATM, UNAIDS, UNFPA and UNICEF.

3. Did the desk review cover documents relating to both SRH and HIV?
- The desk review covered approx. 34 documents relating to Morocco. These included the national strategic plan for HIV, national strategic plan for RH, family planning action plan, youth programme document, policies, guidelines (such as on gender-based violence, women’s health and adolescent health), meeting reports, research reports and operational tools by non-governmental organizations (NGOs).

4. Was the assessment process gender-balanced?
- 72 people were involved in the assessment: 34 women and 38 men.
- 60 per cent of the service providers and users that were interviewed were women.
- The assessment addressed issues related to gender, such as gender equality, gender-based violence and sex education.

5. What parts of the Rapid Assessment Tool did the assessment use?
- The process used questions based on the Rapid Assessment Tool, adapted to the local context.
- The questionnaires were not used directly because the same questions were incorporated into the interviews with officials, managers and service providers.
- For the data collection, several techniques were used: a literature review, structured interviews and focus groups – with all relevant stakeholders, including officials at central, regional and national partners, international providers and service users.
- Four areas were identified, based on their epidemiological profile for HIV and the presence of pilot projects: Casablanca, Rabat, Sous Massa Drâa and Marrakech-Tensift-El-Haouz.

6. What was the scope of the assessment?
- The assessment focused equally on SRH and HIV. However, the SRH component primarily addressed RH, as the concept of sexual health is not formally used in Morocco.
- The assessment aimed to inform the development of a national action plan to strengthen links between different programmes. The research fed into a national planning workshop.
- The fieldwork was conducted in four regions, sampled to provide the most interesting and relevant examples, as many key interventions are not widely implemented in Morocco.

7. Did the assessment involve interviews with policy-makers from both SRH and HIV sectors?
- Interviews were held with: 11 national decision-makers working on health and population; four national NGOs; and five representatives of technical and development assistance partners.

8. Did the assessment involve interviews with service providers from both SRH and HIV services?
- Interviews were held with 39 service providers.
- Six focus group discussions were conducted with health care and outreach workers.
- The service providers were from both RH and HIV facilities, including: health centres, family planning referral centres, youth-friendly services, gender-
Based on violence prevention/information/treatment services and RH centres (AMPF and IPPF).

9. Did the assessment involve interviews with clients from both SRH and HIV services?

- Three focus group discussions were held with service users – one with PLHIV, one with women users of RH services and one with young people in a youth centre.

10. Did the assessment involve people living with HIV and key populations?

- A focus group discussion was held with PLHIV.
- The assessment addressed issues relating to PLHIV, such as their access to medical services, for example antiretroviral therapy (ART) and treatment for opportunistic infections, and psycho-social support.

FINDINGS

1. Policy level

**National policies, laws, plans and guidelines:**

- The term ‘sexual health’ is not in common use. Reproductive health is, but no entity has overall responsibility and there is no specific RH action plan or funding. RH includes: maternal, newborn and child health (MNCH), antenatal care (ANC) and delivery, integrated management of childhood illnesses (IMCI), family planning, young people’s health, HIV and sexually transmitted infections (STIs), cancer prevention, and addressing gender-based violence (GBV).

- National plans exist for some RH components. Strategy documents and guidelines for MNCH and family planning (FP) have little HIV content. Plans for GBV were being developed at the time of the study.

- The only document with an integrated approach is the National AIDS Strategy 2007–11. MNCH and FP services are identified as priority sites for introducing and strengthening HIV-related interventions. The plan also promotes revised guidelines for syndromic management of STIs.

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- Regional-level HIV plans focus on HIV testing, STI treatment and prevention of mother to child transmission (PMTCT). HIV service delivery is in referral facilities and NGOs. PMTCT and other key interventions are yet to be scaled up.

- The HIV legal environment has improved, with greater support and protection for women’s rights, legal protection for PLHIV from stigma and discrimination, and HIV treatment access.

Funding and budgetary support:

- Within the MOH, because each component of RH and HIV programming is managed by a different entity, funding also tends to be streamed per component.

- Many partners work with the MOH, such as UNICEF, GFATM, UNFPA, UNAIDS and WHO. Each has specific priority areas. For instance, UNAIDS focuses on technical support, UNFPA on development of RH policy and GBV programmes, and UNICEF on paediatric HIV and PMTCT.

- The MOH has action plans with each partner. This can make coordination problematic – better coordination would be achieved if all partners bought into an overall MOH plan.

- GFATM projects in principle support integration, such as via PMTCT expansion, universal precaution interventions, integrated RH and HIV for school health clubs, and support to NGOs.

2. Systems level

- The ‘vertical’ policy approach is reflected in systems. Some components are grouped together by necessity rather than design – in small facilities, MNCH and FP services are provided together. HIV services are provided through specialized referral centres and NGOs.

Partnerships:

- NGOs are key actors in the delivery of HIV services and often do this through formal partnerships with the MOH. In some cases, they deliver services within MOH facilities.

- Regional AIDS Committees ensure coordination of the HIV response. Mechanisms for other components are
less systematic and are project, rather than system, based.

**Planning:**
- Planning committees exist for some, but not all, components of RH and HIV. The planning of each component remains largely vertical.

**Human resources and capacity building:**
- Although the assessment report does not include quantitative data, it suggests that there are significant human resource gaps in the health sector.
- Training is often provided on specific technical areas – like STI management and youth services – rather than comprehensive SRH and HIV. Some projects are exceptions, such as training under AMPF which takes an integrated approach.

**Logistics, supply and laboratory support:**
- A 2007 review of supply and management showed weaknesses in quantification and coordination problems between the departments ordering and those distributing condoms. The assessment proposes systems to tackle this and to introduce integrated ordering of SRH products.

**Monitoring and evaluation:**
- There are no integrated SRH and HIV indicators.
- Monitoring teams for MOH services exist, but tools are not standardized and are more likely to exist where they relate to externally funded programmes. Indicator standardization is lacking even within specific, established components such as MNCH or FP.
- Future development of monitoring systems, including the shift from disease monitoring to overall health monitoring, provides an opportunity to rationalize and integrate M&E for SRH.

### 3. Services level

#### A. SERVICE PROVIDER PERSPECTIVES

**HIV integration into SRH services:**
- Organization of service provision varies in rural and urban settings. Normally in each health facility there is a doctor, practitioners and MNCH unit. In rural areas, one or two nurses look after all MNCH. In urban areas, there is one unit for infant health, one for FP and one for ANC.
- Confidentiality within these health facilities is problematic. For example, in FP services, several patients attend at the same time. Interpersonal communication and counselling are rarely feasible. Spaces are not large enough to enable group work sessions.
- According to health workers, contraception is accessible, including for unmarried women.
- Facilities do not provide many materials, apart from a dated set of FP guidelines.
- Doctors say they are overburdened (40–50 patients a day) and find it hard to be proactive.
- There are good examples of facilities organizing integrated services. In Casablanca, ANC doctors are trained in STI provision, while an NGO provides HIV testing services within the same building, facilitating referrals.
- Half of those interviewed had never had training on STI management. In addition, HIV testing is rarely provided in the context of STI treatment. STI drug stock-outs are common.
- For specialized diagnoses, referrals are required and costs to the patient are higher, leading to lower uptake.
- Condoms are available in some health facilities, through either the FP or STI channel. Very few men and young people come to request condoms from health facilities.
- PMTCT is provided only in specialist referral facilities in a small number of cities. Although there is high acceptance of HIV testing (100 per cent according to the report), provision of counselling is problematic, given that privacy is hard to guarantee in many facilities.
- Some ANC nurses are concerned that the introduction of PMTCT will affect the time they can spend on doing effective ANC.
- The range of services in facilities is varied, with some addressing a broad range of SRH subjects including violence, stigma and gender.
- Condoms are not always available, which is problematic – it can be difficult for young people to get condoms from doctors.
- Many centres do not provide information on a comprehensive range of SRH topics.
- There are guidelines for care and support for women and children affected by violence. But the service is not delivered everywhere and many aspects are
missing, such as the morning-after pill, STI treatment, HIV testing and post-exposure prophylaxis [PEP].

- Maternity facilities deal with PMTCT, but not other issues such as cervical cancer or risky pregnancy etc.

**SRH integration into HIV services:**

- HIV services are mainly provided in specialized facilities and by NGOs.
- RH services are generally not provided in the context of services for PLHIV. For instance, some of the facilities providing treatment do not provide contraception or condoms.
- Many specialist facilities work in collaboration with NGOs, for example in the provision of counselling and psychosocial support.
- There are no guidelines on what psychosocial support involves, and little training or time is given to service providers. Some NGOs provide support in the form of food packs, support for adherence to treatment, financial support and income generation activities. But funding and training to do this is limited, and only adherence support is well implemented.

**NGO perspectives:**

- As noted, NGOs are major contributors to HIV services.
- ALCs has testing centres and outreach for key populations, providing targeted services and addressing rights and discrimination. They are not as active on RH.
- AMPF has SRH centres, youth centres and mobile facilities. They have the most integrated approach, addressing unsafe abortion, rights, stigma and male involvement. Staff training and clinical services are limited. Strengthening of referral systems are seen as a need.
- OPALS provides focused STI and HIV services, including testing and treatment adherence support. They refer to health centres for other services. Integration of RH is ongoing.
- Association du Jour is a PLHIV association, primarily providing psychosocial and economic support, access to treatment and support groups.
- Partnerships between NGOs and the MOH are strong and include secondment of clinical staff and provision of materials and office space.

**B. SERVICE USER PERSPECTIVES**

**PLHIV focus group:**

- PLHIV receive services from NGOs and specialized centres. On the whole, they are happy to attend specialized centres – as there are no other options for receiving care. Psychosocial support is seen as particularly important, although it is not widely available.
- Key challenges identified include: distance from treatment facilities; outdated treatment regimens; having to pay for diagnostic tests; and insufficient availability of psychosocial support. Stigma and discrimination also continue to affect PLHIV.
- Respondents also said they faced difficulties accessing RH services as they are often not available in HIV treatment facilities. Most PLHIV only have access to condoms for contraception. In general, access to RH services for PLHIV is limited.

**AMPF youth focus group:**

- In general, young people are happy with the services at the youth centre – which are easily accessible and friendly, and address recreation and basic education as well as health.
- The main topics covered are HIV, STIs, tobacco and drugs, with some attention to other issues, including RH. Few young people cited health as being a major concern.

**Women attending health centres focus group:**

- Most of the women were familiar with the centre. They had been attending it for some time and were happy with the waiting times and reception.
- Access to medicines was reported as variable. However, the respondents accepted that they would be required to pay for some medications.
- Key priorities for services are that they are not far away and that providers are friendly.
- Respondents did not cite RH services as being their main need. However, most were unaware of the existence of RH services other than for ANC and FP.
LESSONS LEARNED AND NEXT STEPS

1. What lessons were learned about how the assessment could have been done differently or better?

- The assessment focused primarily in areas where services are provided rather than in those where they are not. As such, it provided a limited view of integration throughout the country.
- The assessment report is repetitive and does not cite a lot of quantitative data. As such, it is difficult to assess the scale and statistical reliability of the findings.
- It would have been beneficial to involve other RH and HIV stakeholders in the assessment, such as the Ministry of Youth and Sports, Ministry of Social Development, private sector, religious institutions and other development NGOs.

2. What ‘next steps’ have been taken (or are planned) to follow up the assessment?

- Organizing a national workshop to present the results of the assessment and develop and validate the recommendations. Key strategic actions included:
  - In the short term, developing a steering committee of representatives of RH programmes, organized by the Ministry of Health, with the Secretary General as the Chair and a technical director (rotating or designated by the Chair) as Vice President. Also developing a national RH commission, composed of the MOH, other government departments, the private sector and NGOs.
  - In the long term, reviewing the organizational RH structures of the MOH and integrating good practice from international experiences.
  - Developing an action plan to integrate RH and HIV in the strategic plan of the MOH.

3. What are the priority actions that are being taken forward as a result of the assessment, at the:

- Policy level?
- Systems level?
- Services level?

Policy level:
- Establishing a national RH steering committee composed of representatives of RH programmes of the Ministry of Health.
- Creating a national RH fund to support sustainability.

Systems level:
- Developing the national RH committee to include the MOH, other government departments, industry, private sector and NGOs.
- Establishing coordination committees and mechanisms.
- Applying the process at the regional/provincial/local levels.
- Creating a national RH fund to support sustainability.
- Promoting coverage of RH services by social medical insurance.

Services level:
- (under way) Bringing together the components of RH and HIV programming to form RH reference centres at the regional level: STIs/HIV, FP, monitoring of pregnancy and delivery, screening and treatment of genital cancers and maternal morbidity.

4. What are the funding opportunities for the follow-up and further linkages work in the country?

- The MOH has committed to supporting the action plan to integrate RH and HIV services. The plan is integrated into the MOH’s strategic plan for 2008–12.
- Family planning reference centres will be restructured to integrate all components of RH.
- Attention to RH and HIV integration was incorporated into Morocco’s proposal to Round 10 of the GFTAM.
Abbreviations

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
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<tr>
<td>ALCS</td>
<td>Association de Lutte contre le Sida</td>
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<tr>
<td>AMPF</td>
<td>Association Marocaine de Planification Familiale</td>
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<tr>
<td>ANC</td>
<td>antenatal care</td>
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<td>ART</td>
<td>antiretroviral therapy</td>
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<td>ARV</td>
<td>antiretroviral</td>
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<td>FP</td>
<td>family planning</td>
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<td>GBV</td>
<td>gender-based violence</td>
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<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>GNP+</td>
<td>Global Network of People Living with HIV</td>
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<td>HIV</td>
<td>human immunodeficiency virus</td>
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<td>ICW</td>
<td>International Community of Women Living with HIV/AIDS</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<td>M&amp;E</td>
<td>monitoring and evaluation</td>
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<td>MCI</td>
<td>management of childhood illnesses</td>
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<td>MNCH</td>
<td>maternal, newborn and child health</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>NGO</td>
<td>non-governmental organization</td>
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<td>OPALS</td>
<td>Organisation Panafricaine de Lutte contre le Sida</td>
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<tr>
<td>PEP</td>
<td>post-exposure prophylaxis</td>
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<tr>
<td>PMTCT</td>
<td>prevention of mother to child transmission</td>
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<td>PLHIV</td>
<td>people living with HIV</td>
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<td>RH</td>
<td>reproductive health</td>
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<td>SRH</td>
<td>sexual and reproductive health</td>
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<td>STI</td>
<td>sexually transmitted infection</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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